INFLUENZA VACCINE 2018-2019
HEALTH SCREEN & PERMISSION FORM

NPI: 1265651814-002

School Name: _____

*Full Name:	*Date of Birth: / /	Age:	*Gender: ☐ M ☐ F
*Street Address:	*Town/City:	*Zip Code:	Daytime Phone:
Grade:	Teacher:	School Administrative Unit (District)	

*Required

Is this person an American Indian or an Alaskan Native? ☐ yes ☐ no

Is this person uninsured? ☐ yes ☐ no

Is this person insured by MaineCare (Medicaid)? ☐ yes ☐ no

MaineCare ID #: _____

Private Insurance? ☐ yes ☐ no

Name of Insurance Company: _____

ID Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Doctor's Name: _____ Phone Number: _____

Please answer the following questions about <u>the person named above</u>. Comments may be written on the back of this form.

	YES	**NO**
1) Does this person have a severe (life-threatening) allergy to eggs?		
2) Has this person ever had a severe reaction to an influenza immunization in the past?		
3) Has this person ever had Guillain-Barre Syndrome?		

If you answered "yes" to any questions 1-3, please see your healthcare provider for influenza vaccination

PERMISSION TO VACCINATE

- I was given a copy of the Influenza (Flu) Vaccine Information Statement, I have read this or had this explained to me and I understand the benefits and risks of the Influenza vaccine.
- I give permission for a record of this vaccination to be entered into the ImmPact Registry.
- I give permission for information to be used to bill MaineCare or private insurance for the cost of providing the vaccine
- I give my consent for this person to receive the most appropriate vaccine, as determined by the health care clinic staff.
- **I give permission for the flu vaccine to be given to the person named above by signing below.**

X _____ Date: _____

Signature of parent or guardian if person to be vaccinated is a minor or Signature of adult to be vaccinated

Printed Name of Parent or Guardian**:** _____

FOR OFFICE USE ONLY:

Date Dose Administered	**Vaccine Manufacturer**	**Lot Number**	**Dose Volume**	**Signature and Title of Vaccinator**	**Body Site**	**Route**	**VIS date**
/ /						☐ IM single dose ☐ IM multi vial	State Supplied Y N

UMMS Provider Code: 116737196